CITY OF RIVERSIDE
HEALTH INSURANCE
REIMBURSEMENT PROGRAM

Employee Name_____ Date of Hire_____

Employee ID #_____ Bargaining Unit_____

I am/will be enrolled in_____ _____ through_____
(Name of current/future health provider) (Spouse or Another Source)

and have attached proof of current coverage for the upcoming year. The only acceptable proof is a letter from either the plan provider or spouse's employer stating that you are covered for the upcoming year or a copy of current medical card and/or copy of enrollment form as proof of coverage.

I may also be requested, at the end of the upcoming year, to provide proof that I was covered under my spouse or another source for that entire year. If information is not submitted this will automatically forfeit my rights to the Health Insurance Reimbursement Program for that year.

If I am mandated by a Court Order to provide medical coverage for my dependents, I am aware that I must request enrollment for my dependents and myself immediately. Coverage will be effective the first day of the month following submission of an enrollment form and a copy of the Court Order. This will automatically forfeit my rights to the Health Insurance Reimbursement Program for that year.

If my dependents or I lose health insurance coverage, I must request enrollment within 30 days of the loss of coverage. Coverage will be effective the first day of the month following the loss of coverage date. An enrollment form along with written proof of loss of coverage must be submitted. This will automatically forfeit my rights to the Health Insurance Reimbursement Program for that year.

Employees must be employed through the end of the last payroll period in November to qualify for this benefit. Current employees on payroll through November who did not work the entire 12-month period shall earn the stipend on a pro-rata basis.

I acknowledge that my employer has explained the available coverages to me, and I understand that I have every right to apply for coverage. I have been given the opportunity to apply for coverage and I have decided not to enroll myself, and if applicable, my dependent(s). I have made this decision voluntarily without the influence of a third party. I also acknowledge that in declining coverage, through the City, I must provide proof of health coverage through spouse or another source or forfeit my rights to the Health Insurance Reimbursement Program for that year. I am aware that the money received is considered taxable income.

_____ _____
Employee Signature Date

☞ **Health Insurance Waivers are subject to Annual Verification. You will be required to complete a Health Insurance Waiver Verification form and submit proof of current coverage during the Annual Open Enrollment period each year.**